Factors Affecting Health Seeking & Utilization of Curative Health Care

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FACTORS AFFECTING HEALTH SEEKING

AND

UTILIZATION OF CURATIVE HEALTH CARE

MARCH 1997

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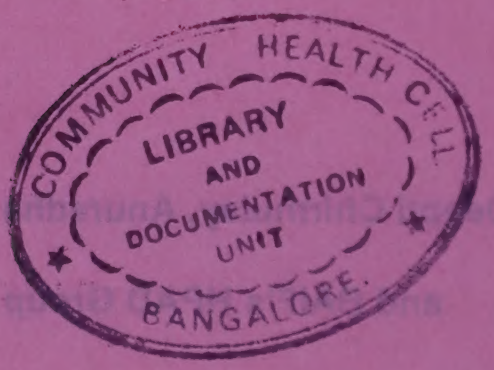

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FACTORS AFFECTING HEALTH SEEKING AND UTILIZATION OF CURATIVE HEALTH CARE

Executive Summary

Treatment of symptoms and curative health services is the prime, perceived health need of the people. The decision about utilization of health care facilities, besides physical access, may be associated with the quality of services on one hand and socio-economic factors on the other. For improving the reach of health care, especially to the remote and poorer rural communities, it is essential to understand their choice and reasons for the choice.

Under the auspices of the **International Health Policy Programme (I.H.P.P), Washington D.C., BAIF Development Research Foundation** - a non-profit voluntary organization engaged in rural development and research - conducted a cross-sectional study in selected rural areas from five states in India. The objectives were to study the preferences of the people regarding choice of health care provider in relation to their socio-economic backgrounds, identify the factors influencing these decisions, and to identify necessary interventions for increasing reach of health services to the poorer people.

The analysis of extensive quantitative and qualitative data collected, brought forth the following conclusions and Policy recommendations :

1. The quality of services was an important determinant of the utilization pattern and the quality of services provided by the PHC(s) or Govt Hospital was perceived to be poor. On the other hand the poor were found to be dependent on the PHC services for curative care, our recommendation is that **curative capacities of the PHC structure and the staff should be enhanced and their presence ensured.**

2. Private modern medicine practitioners were the most popular choice of treatment, who were seen to be imparting irrational treatment. **Continuing medical education for the private practitioners** is also necessary to upgrade their knowledge and prevent irrational use of medicines along with a stricter control.

3. Economic factors restrict accessibility to private practitioners of modern medicine. **Programmes to improve the economic condition of the poor rural households should go hand in hand with the development of health infrastructure.**

4. Caste had a significant contribution in the choice of services in all areas except Garag (Karnataka). Dominant and Higher caste groups preferred private medical care, and SC and ST were relying on the traditional healers. **Traditional healers who were consulted by the socio-economically backward households, and the herbal medicines should be integrated in the health system.**

5. The educated clearly preferred the private practitioners. **Raising awareness about common ailments, their management and prevention is very essential, to prevent** wastage of the scarce resources on inappropriate treatments.

6. In case of Raila (Raj), where infrastructure was under-developed, the facilities for health care were very poor. Observations in the area showed that even serious cases were treated at home. **Development of relevant health care infrastructure in the remote areas** is thus a priority for the development action.

7. **No gender related differences** were noted in the reported morbidity and treatment seeking in our study. However, only in Karchhana (U.P.), significantly more males were treated at the PHCs. Whether this is related to the gender of the health care provider needs to be further investigated. Private care was availed of by males and females in equal proportions.

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FACTORS AFFECTING HEALTH SEEKING

AND

UTILIZATION OF CURATIVE HEALTH CARE

Treatment of symptoms and curative health services is the prime, perceived health need of the people. Over the centuries of history of development of medical science and services; several pathies have evolved in India. The major tradition - Aayurweda - has very deep roots in the Indian Health Care System. Minor traditions practised by the local healers are even today the mainstay of primary treatment and the first contact care in rural India. Allopathy has taken roots in India and dominates the medical care scenario in Urban areas. Medical pluralism is an inevitable result of this health system.

Decisions related to seeking health care when sick, choice of pathy and the level of health care, and option for Government provided or private medical care; vary considerably across the community groups. The decision about utilization of facilities, besides physical access, may be associated with the quality of services on one hand and socio-economic factors on the other.

For improving the reach of health care, especially to the remote and poorer rural communities, it is essential to understand their choice and reasons for the choice. What are the factors which prompt a person or a family to seek care, and what does the choice depend on ? Only in-depth understanding of the health behaviour of the people can throw light on the relative influence of various socio-economic factors on the health seeking behaviour. Our study therefore attempts to understand the factors which may influence decisions regarding the choice of services.

Comparison of pattern of health care seeking across different socio-cultural, and infrastructure and facility situations; can help in understanding the inter-relations and relative role of the factors like social and economic access to health care, and role of education in the choice of health care and provider.

Objectives

1. To study the preferences of the people regarding choice of health care provider in relation to their socio-economic backgrounds.

2. To identify the factors influencing decisions regarding type of health services used.

3. To identify necessary interventions for increasing reach of health services to the poorer people.

Methodology

Under the auspices of the International Health Policy Programme (I.H.P.P), Washington D.C., BAIF Development Research Foundation - a non-profit voluntary organization engaged in rural development and research - conducted a cross-sectional study in selected rural areas from five states in India, namely Gujarat (District Valsad), Maharashtra (District Ahmednagar), Karnataka (District Dharwad), Uttar Pradesh (District Allahabad) and Rajasthan (District Bhilwada).

Information was collected for more than 3000 households in each of the study areas. An attempt was made to cover all households in each selected village, but roughly 90 per cent of households could be covered owing to absence of some families from the village at the time of the survey.

For collection of cross-sectional quantitative data, an interview schedule was used. The interview schedule contained questions relating to demographic information, socio-economic status of the household, morbidity in the previous week, morbidity for specific ailments, and type of treatment taken.

In addition to the **quantitative information** collected through the interview schedules, **qualitative information was** also collected. The focus of the qualitative information was the health culture of the area and health seeking behaviour. Information collected included parameters such as Traditional health practices, concept of health and disease, the perceived quality of services at Primary Health Centres and Government hospitals, the availability of private modern health practitioners and accessibility to the various types of services. The qualitative information was collected by an anthropologists who resided in the study areas for up to three months. Guidelines for informal in-depth interviews and focus group sessions were used.

Analysis

The interview schedule carried a question on morbidity in the household during the week preceding the survey and types of treatment sought. The schedule provided options for treatment sought which were as follows :

No treatment
Resort to **home level remedies,**
Resort to **traditional practitioners,**
Treatment from the **ANM / FHW** visiting the village,
Treatment from the Primary Health Centre (**PHC**) or **a Government Hospital,**
and
Treatment from **private practitioners** of medicine.

SPSS for Windows software was used for the statistical analysis. Univariate and bivariate analysis for type of treatment sought vis a vis morbidity was done to understand the utilization pattern across different socio-economic groups. Multivariate analysis using regression technique was done. Use of private medical care, use of PHC facility and lack of treatment were used as dependent variables in three separate equations. Various socio-economic factors were used as independent variables, to identify those influencing decisions.

Results

No significant differences were noted in the morbidity prevalence, pattern or treatment seeking behaviour of male and female members, and hence the analysis has been presented as on the total population.

Morbidity pattern

Dis-aggregate figures for the individual type of morbidity were small, with fevers and coughs being the commonest complaint reported, followed by diarrhoea, pain in abdomen and other minor complaints. **Table 1** gives the incidence of morbidity in the week preceding the study, reported loss of work due to sickness and the types of treatment sought in case of morbidity, in the total population.

Table 1 : Morbidity in the total population and treatment taken

PARTICULARS	**GANDEVI (GUJ)**	**AKOLE (MAH)**	**GARAG (KAR)**	**KARCHANA (U.P)**	**RAILA (RAJ)**
Total populn.	14464	17539	20084	16410	15126
Reported sick	261	756	758	1062	487
% popln. sick	1.8	4.3	3.8	6.5	3.2
% Without treatment	3.8	10.1	21.3	9.3	15.4
% Treated with home remedies	9.5	15.1	3.0	17.2	55.0
% treated by Trad. healers	1.1	1.6	3.2	0.9	18.5
% ANM treated	0.8	0.1	0.4	0.2	3.5
% PHC service	20.5	17.9	22.3	16.1	47.6
% Private practitioners	73.0	66.4	54.6	66.4	9.2
% reported unable to work	53.2	74.5	19.2	31.5	52.6

Morbidity reported during the week preceding the survey varied across the study areas, and ranged between less than 2% to 6% of total population. Similarly reported loss of work varied too, between one in five to three fourths of patients. A variable number, roughly parallel to the reported loss of work, received no treatment. (3.8% to 21.3%)

Choice of Health Care Provider

From **table 1** it is evident that the Private modern health care services were the most popular choice in four out of the five study areas (54.6% to 73%); except in Raila (Raj) (9.2%), where home level care was resorted to by the majority (55%) followed by the PHC (47.6%).

PHC services for overall morbidity in the previous week were used most popularly by the people from Raila (Raj) (47.6%), and least by the people of Karchhana (U.P.) (16.1%). In other areas the utilization of PHC for curative services was around one in every five to six patients.

Home remedies were used by a variable number between 3% to 17.2%, except in Raila (Raj) where they were practised more commonly (55%). Figures for treatment from traditional healers were nominal for all areas, except Raila (Raj), where local healers - Devata - were very popular.

Even though provision of primary treatment is one of the functions of the Auxiliary Nurse Midwife (ANM) or the Female Health Worker (FHW) working under the PHC set up; in no place was she found to be doing this. Less than one in hundred patients received treatment from the ANM. Only in Raila (Raj) a little more (3.5%) patients were treated by the ANMs.

Reasons for the choice

Our qualitative observations and findings also confirmed that the first preference was the resort to modern private health care practitioners in all the areas, although traditional healers were preferred in specific instances and in case of specific ailments like psychiatric problems.

In Raila (Raj) the Traditional Healers had a very strong hold on the minds of the people. Here they were consulted first, even to ask for permission to seek care from the modern medical practitioner.

Typhoid Fever in Raila (Rajasthan)

At the time of our study in the villages surveyed, almost every household had a patient of Typhoid fever (known as NIKHALO or MIYADI BUKHAR in Rajasthan), being treated at home with dietary restrictions and ashes (VIBHUTI) given by the local healer.

Diseases like Typhoid fever were considered to be a result of wrath of Goddess - Devata. The Traditional Healer was believed to be an incarnation of the Goddess and hence was also referred to as Devata. The Devata would diagnose Typhoid fever by the smell of the cloths worn by the patient, predict the number of days the patient will suffer and conveys the demands of the Goddess which were acted up on for the cure of the ailment.

The doctors from the Government hospital told us about several patients treated by them for complications of Typhoid fever like intestinal perforation and septic shock, encountered commonly in the area.

The most important reason for preferring private modern health care facilities to the Government health facilities was the **perceived quality of care.** The Govt health services were not popular on account of the longer waiting period, arrogant behaviour and attitude of the doctors as well as the para-medical staff, and non-availability of medicines. The plus point for the private practitioners was inclusion of injections as a part of every treatment. Besides this the private practitioners were very willing to make home visits to examine and treat patients, which was very convenient, especially when the transport facilities were very poorly developed.

Jhola Chhap Doctors and Popularity of Injections

Several of the private modern medicine practitioners found in the study areas were the **Registered Medical Practitioners (RMP)**. When doctors were scarce in India, experienced para-medical workers, who had worked with doctors for several years were certified as RMP and allowed to treat patients. Subsequently this procedure was stopped. However, several courses in alternate medicine have mushroomed, as well as several self-proclaimed doctors have emerged, who are practising medicine in rural areas. In Karchhana (Uttar Pradesh) they are popularly called **"Jhola Chhap"** doctors, since they carry their medicines and equipment around in a bag - Jhola.

These **RMPs** were the preferred alternative since they were easily approachable and resided in the village itself, practised in an ambulatory fashion, were willing to treat on credit and **"belonged to the community itself."**

For majority of the people staying in the study villages, daily wage was the only source of livelihood. Due to this situation, they could not afford to stay back at home for long time during their sickness. Injections were believed to provide quick relief and shorten the total duration of the illness. This myth was perpetuated by the local doctors, as it also helped them charge higher fees for their services.

In the areas included in this study, a person was believed to be sick only if the person was unable to work (physically), had lost appetite and interest in the surroundings, was unable to move about or participate in social exchange. Absence of these features was healthiness. Considering this definition of health in the rural areas, it was inevitable that the private sector which offered quick-fix treatment, was so popular.

Besides this, private medical care being an expensive affair, using these facilities or being able to afford these, was an indirect status symbol. Which got translated as a proxy for 'caring attitude' or 'having done every thing possible' for the patient in areas like Akole (Mah) and Karchhana (U.P.).

But in case of Raila (Raj) private facilities were not very well developed. Practitioners of Allopathy were situated as much as 35 to 40 kilometres away from the villages. Only source of modern medical care was PHC and those who could, went to PHC which was also at a considerable distance from the villages. In PHC too, people expected to receive injections for treatment.

Observations in Raila (Raj) showed that faith in traditional remedies and widespread knowledge of herbal medicine was one more possible explanation for the lower popularity of the private modern practitioners. At the same time, there was a stigma attached to visiting these doctors who mainly specialized in treating sexually transmitted diseases. This consciousness about stigma attached considerably increased as we moved from lower to higher castes, thus explaining the popularity of the PHC among the higher castes.

Thus the main reasons for the choice and the preference for private medical care were :

1. Perceived better quality of care.
2. Easy physical access to services.
3. Status symbol and concept of caring.

Variation and preferences across the study areas

In **Gandevi (Guj)**, apart from the financial position, factors like highest education in the family and caste determined the choice of health services. As compared with the other four areas, the educational levels in the survey villages in Gujarat were higher. Education had generated an awareness about treatment of symptoms and about the quality of care, which determined whether treatment was resorted to or not. This explains why only a marginal proportion received no treatment.

In **Akole (Mah)**, modern private health care practitioners were preferred since the Rural Hospital was characterized by queues and long waiting hours, non-availability of doctors, insufficiency of medicines which were often prescribed rather than given, and the uncaring attitude of doctors. Here, the financially better off had a higher educational level and belong to the higher castes, also tended to prefer private to the PHC services.

Qualitative information about our survey area **Garag (Kar)** indicated that there were strong cultural beliefs and practises characteristic to the whole area and operating irrespective of caste. Hence behavioural patterns tend to be uniform across castes. However, households with very low asset holding tended to avoid seeking treatment.

In **Karchhana (U.P.)**, the highest education in the family was also seen to be associated with the choice of treatment. The PHC was considered to have, insufficient facilities. Another complaint was that medicines were prescribed rather than given directly. The 'Jhola Chhap' doctors prevalent in the area were the most popular for curative care.

In **Raila (Raj)**, where PHC was more popular than private due to various factors like non-availability of private centres, strong beliefs about traditional healing practices, stigma attached to private doctors who treated sexually transmitted diseases. Higher caste people tended to avail of the PHC services more, but the educated tended to seek private care.

Affordability and utilization

We made an attempt to study utilization of health care facilities across asset-holding categories in order to assess whether preferences were related to the affordability factor, using the chi square test for significance. As can be seen from the **table 2**, affordability is a very important factor in the choice of health care provider in four out of five study areas.

Financial condition would weigh the decision to seek care and then the type of treatment sought. Households with higher value of total asset-holding had higher proportions of patients seeking private medical care (except in Raila, Rajasthan and not significant in Garag, Karnatak). On the other hand, lower the asset-holding more was the proportion of lack of treatment (in all areas, not significant in Raila, Rajasthan) or resort to PHC facility (in Gandevi, Gujarat and Akole, Maharashtra). Details of these findings are given in **Annex I**.

Table 2 : Significance of differences in treatment by asset-holding in the household.

SOURCE OF TREATMENT	**GANDEVI (GUJ)**	**AKOLE (MAH)**	**GARAG (KAR)**	**KARCHANA (U.P.)**	**RAILA (RAJ)**
No treatment	*	*	**	**	NS
Govt. PHC	*	**	NS	NS	NS
Private care	**	**	NS	**	NS

Note : * = < 0.05, ** = <0.01 and NS = Not Significant.

Role of Caste and Culture in the utilization of care

Social access to health care was considered as a factor, equally important as the economic access or affordability. Socially dominant groups often have more access or even monopolize certain resources. This was examined by dis-aggregate analysis by caste groups. **Table 3** gives the comparative picture in the five study areas. Caste group was an important factor in the choice of care, except in Garag (Kar). In Garag, traditions and culture had a very strong hold on the community. Relatively uniform behaviours were observed across caste, and economic groups in this area.

Table 3 : Significance of differences in treatment by Caste groups in the five study areas.

SOURCE OF TREATMENT	GANDEVI (GUJ)	AKOLE (MAH)	GARAG (KAR)	KARCHANA (U.P.)	RAILA (RAJ)
No treatment	NS	**	NS	*	NS
Govt. PHC	NS	**	NS	NS	**
Private care	**	**	NS	*	**

Note : * = < 0.05, ** = <0.01 and NS = Not Significant.

Persons from Dominant and Higher caste groups were more likely to receive care from a private practitioner, where as those belonging to Scheduled Castes (SC) or Scheduled Tribes (ST) would take no treatment or go to the PHC (in Akole, Mah.). In Raila (Raj), however, lack of treatment was not dependent on caste, and Dominant and Higher caste groups were more likely to use the PHC and private care, and SC or ST went to the Traditional healers. **Annex II** gives the details.

Effect of highest education in the family on utilization

Educational levels are often used as proxy for the awareness levels. Educational level could define psychological access to health facilities. On the other hand, education helps in securing jobs and bettering the economic status. This factor was thus examined, using the highest level of education in the family. **Table 4** gives the influence of education on treatment seeking.

Education on the whole did not influence lack of treatment or the PHC use, except in Gandevi (Guj) and Akole (Mah) where it negatively influenced PHC use. However, higher the education, more was the use of private medical care, except in Garag (Kar). The details are given in **Annex III**.

Table 4 : Significance of differences in treatment by Educational level in the household.

SOURCE OF TREATMENT	**GANDEVI (GUJ)**	**AKOLE (MAH)**	**GARAG (KAR)**	**KARCHANA (U.P.)**	**RAILA (RAJ)**
No treatment	NS	*	NS	*	NS
Govt. PHC	*	**	NS	NS	NS
Private care	**	**	NS	*	**

Note : * = < 0.05, ** = <0.01 and NS = Not Significant.

Factors contributing to the decisions to seek care from various providers of medical care

To understand the decision making process of the rural households regarding the medical care, three separate regression equations were developed. The independent variables used were common to the three equation. The dependent variables were : No Treatment, Treatment from PHC, Treatment from Private practitioner. **Tables 5, 6 and 7.**

It was very clear that the loss of (capacity to) work was the single most important factor. It was negatively related to 'No Treatment', and significantly positively related to seeking 'Private Medical treatment'.

Table 5 : Factors contributing to lack of treatment in five areas

Independent Factor	Gandevi (Guj)	Akole (Mah)	Garag (Kar)	Karchhana (U.P.)	Raila (Raj)
Caste Group	NS	NS	NS	*	NS
Highest Education	NS	NS	NS	NS	NS
Male sex	NS	NS	NS	NS	NS
Total asset holding	NS	NS	NS	- *	NS
Work loss	NS	- **	- **	- **	NS

Note : NS = Not Significant, * = < 0.05 , ** = < 0.01

It is apparent from the **table 5** that minor ailments, not affecting a person's ability to work, are usually left untreated by all sections in the society. Besides this, in Karchhana (U.P.), lack of assets (poverty) and belonging to Scheduled Caste (SC) group, independently hampered treatment seeking.

Table 6 : Factors contributing to seeking treatment from PHC

Independent Factor	Gandevi (Guj)	Akole (Mah)	Garag (Kar)	Karchhana (U.P.)	Raila (Raj)
Caste Group	NS	NS	NS	NS	*
Highest Education	NS	NS	NS	*	NS
Male sex	NS	NS	NS	*	NS
Total asset holding	NS	- **	NS	NS	NS
Work loss	NS	*	NS	*	NS

Note : NS = Not Significant, * = < 0.05 , ** = < 0.01

PHC facility was poorly utilized in all areas, however, whenever used, the reason was 'loss of work' and households with very low asset holding were the ones to avail of this facility (Akole, Maharashtra). In Karchhana (U.P.), PHC was used more by households with higher levels of education and by male members. In Raila (Raj), PHC was far away from the people, and persons belonging to higher caste groups availed of the facility more often than those from lower caste groups.

Besides the 'loss of work', other factors contributing to the choice of private treatment were, higher educational level in the household (Gandevi, Gujarat and Raila, Rajasthan) and more asset holding in the household (Akole, Maharashtra and Garag, Karnatak). In Akole (Mah), Scheduled Caste (SC) and Tribe (ST) persons seldom used the private care.

Table 7 : Factors contributing to seeking Private treatment.

Independent Factor	Gandevi (Guj)	Akole (Mah)	Garag (Kar)	Karchhana (U.P.)	Raila (Raj)
Caste Group	NS	**	NS	NS	NS
Highest Education	*	NS	NS	NS	*
Male sex	NS	NS	NS	NS	NS
Total asset holding	NS	**	#	NS	NS
Work loss	NS	**	*	**	NS

Note : NS = Not Significant, * = < 0.05 , ** = < 0.01
= Approaching significance.

In Raila (Raj), a larger proportion (18.5%) of people preferred to go to local healer called as Devata for treatment, as compared to other states.**(Table 1)**. Here the regression analysis failed to reveal any contribution of factors like caste group or asset holding or education in the household. However, here too the factor, loss of work, was very highly significant; elaborating the chief concern of the people, their ability to function normally.

Who used the PHC services ?

Amongst the PHC users, the majority were from lower asset holding households, or belonged to the SC or ST groups, in all the study areas except Raila (Raj). **Table 8** gives the profiles of PHC users from the five study areas.

Table 8 : Profiles of PHC users in the five study areas.

Particular	Gandevi (Guj)	Akole (Mah)	Garag (Kar)	Karchhana (U.P.)	Raila (Raj)
No. of users	53	135	173	171	232
% Assets less than Rs.10000	94.3	74.8	75.7	81.9	57.4
% Dominant Caste group	22.6	54.8	50.3	1.8	32.3
% Scheduled Caste/Tribe	66.1	36.3	24.3	44.4	20.7
% educated above Secon-dary level	26.4	22.2	27.2	53.2	12.5

The majority of the PHC users belonged to the lowest asset holding groups in all the study areas. The poorest were thus seen to be dependent on PHCs for curative services.

Proportion of PHC users belonging to the SC or ST groups was also considerable, except in Raila (Raj). At the same time Dominant caste group seemed to avail of this resource as much as possible too, except in Karchhana (U.P.) where members from educated households were more prone to make use of this resource.

Conclusions and Policy recommendations :

1. Role and Utilization of PHC services -

The quality of services was an important determinant of the utilization pattern. In four out of five states, **the quality of services provided by the PHC(s) or Govt Hospital is perceived to be poor** as compared to the quality of services provided by private practitioners of modern medicine. **The curative services were not provided by the ANM**, despite the fact that her prescribed role and responsibilities include these.

In well developed areas like Akole (Mah) and Ganadevi (Guj), **PHC services were used mainly by the poorer, less educated and SC or ST households**. Where as in Raila (Raj), where the reach of the PHC services was very poor, it was utilized by mainly Dominant and Higher caste groups, indicating limited access for the lower social classes. In Karchhana (U.P.), more educated were more prone to use PHC services; probably due to greater awareness or ability to interact confidently with the PHC staff.

Since the poor are seen to be dependent on the PHC services for curative care, our recommendation is that **curative capacities of the PHC structure and the staff should be enhanced.**

a. This would include **functioning equipment essential for treating emergencies** like cardio-pulmonary resuscitation, severe dehydration, haemorrhages including PPH etc.

b. The PHC doctors should receive **continuing medical education** for sharpening their skills in managing medical emergencies and procedures. The **ANM should receive training in treating common health problems and a well stocked kit for use**.

c. Stocks of medicines maintained at the PHC should be **adequate, appropriate for treating diseases prevalent in the area.**

d. And to ensure presence of staff at the place of service and delivery of good quality of services by the PHC staff, a part of their **emoluments should be linked with the quality and impact** of their performance related to the curative services.

2. Choice of health care provider

Private modern medicine practitioners were the most popular choice of treatment in four out of the five areas, because of provision of injectables and home visits. In Raila (Raj), the stigma attached to frequenting private practitioners and lower access to PHC for the lower castes, were the important factors for PHC use. Home remedies and Traditional healers were most frequently used in Raila (Raj), indicating the need for improving the reach of the PHC services.

Image of PHC services in the minds of the community should be improved. Improvement in the curative services provided by the PHCs, and changing their image through raising awareness and **focused Health Education** (HE) is necessary. H E should emphasize the limited role of injectables in treatment of common ailments and unnecessary expense associated with the use of injecables.

Continuing medical education for the private practitioners is also necessary to upgrade their knowledge and prevent irrational use of medicines by the unqualified persons. **A stricter control** and enforcement of law regarding medical practice, on the private practitioners in the rural areas is also needed.

Traditional healers and herbal medicines should be integrated in the health system, along with the modern medicine. The healers can be trained to use effective and safe modern medicines. On the other hand effective traditional medicines should be incorporated in the kits used by the ANM and Health Guides.

3. Choice of provider vis a vis financial position

The next question is whether people can resort to their **most preferred** choice of treatment, or whether there are obstacles to frequenting the type of facilities preferred.

Our analysis indicates that **economic factors** restrict accessibility to private practitioners of modern medicine. **Asset-holding was the primary factor affecting choice of treatment, in all areas except Raila (Raj).**

Programmes to improve the economic condition of the poor rural households should go hand in hand with the development of health infrastructure.

4. Social background of the family and choice of provider

Caste had a significant contribution in the choice of services in all areas except Garag (Kar). Dominant and Higher caste groups preferred private medical care, except in Raila (Raj), where a larger proportion of higher castes were visiting PHCs, and SC and ST were relying on the traditional healers.

In Karchhana (U.P.), educated families were seen to utilize the PHC services. Where as in Akole (Mah) and Gandevi (Guj), the educated clearly preferred the private practitioners. In Raila (Raj) too educated were seen to be reaching the private facilities.

Education helps in increasing psychological access as well as timely resort of health care. However, unless the misconceptions about disease causation and treatment are deliberately tackled through HE, the scarce resources could be squandered on inappropriate treatments. **Raising awareness about common ailments, their management and prevention is thus very essential.**

5. **Infrastructure, facility and health seeking**

In case of Raila (Raj), where infrastructure was under-developed, the facilities for health care were very poor. Here even though the educated preferred private services, the majority resorted to the PHC services. **Preferences can not be acted upon when there is no choice !.**

A large proportion of cases were treated with home remedies and by the traditional healers. Observations in the area showed that even serious cases needing antibiotics and hospitalization, like patients suffering from Typhoid fever were treated at home, commonly.

Development of relevant health care infrastructure in the remote areas is thus a priority for the development action.

6. **No gender related differences** were noted in the reported morbidity and treatment seeking in our study. However, only in Karchhana (U.P.), significantly more males were treated at the PHCs. Whether this is related to the gender of the health care provider needs to be further investigated. Private care was availed of by males and females in equal proportions.

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Annex - I

PROPORTION OF PATIENTS SEEKING CARE FROM DIFFERENT SOURCES BASED ON ASSET HOLDING IN THE HOUSEHOLD

STUDY AREAS	ASSET HOLDING CATAGORY			
	NO ASSETS	UPTO Rs.10, 000/-	MORE THAN Rs.10, 000/	SIG.OF DIFFERENCE
NO TREATMENT				
GANDEVI (GUJ)				
(N)	86	129	46	
% Patients	8.1	2.3	0	*
AKOLE (MAH)				
(N)	238	154	364	
% Patients	14.3	10.4	7.1	*
GARAG (KAR)				
(N)	387	217	154	
% Patients	24.8	22.6	11	**
KARCHANA (UP)				
(N)	187	687	188	
% Patients	15.5	8.6	5.9	**
RAILA (RAJ)				
(N)	79	195	213	
% Patients	13.9	18.5	13.1	NS
PHC TREATMENT				
GANDEVI (GUJ)				
% Patients	25.6	21.7	6.5	*
AKOLE (MAH)				
% Patients	22.7	30.5	9.3	**
GARAG (KAR)				
% Patients	20.7	23.5	27.3	NS
KARCHANA (UP)				
% Patients	13.9	16.6	16.5	NS
RAILA (RAJ)				
% Patients	55.7	45.6	46.5	NS
PRIVATE TREATME				
GANDEVI (GUJ)				
% Patients	62.8	72.9	93.5	**
AKOLE (MAH)				
% Patients	53.4	62.3	76.6	**
GARAG (KAR)				
% Patients	51.7	56.2	57.8	NS
KARCHANA (UP)				
% Patients	57.2	69.4	64.4	**
RAILA (RAJ)				
% Patients	,10.1	10.3	8	NS
DAI				
RAILA (RAJ)				
% Patients	19	19	17.8	NS

NOTE : Value of assets indicated in the study.

Annex – II

PROPORTION OF PATIENTS SEEKING CARE FROM DIFFERENT SOURCES
BASED ON CASTE GROUPS IN THE HOUSEHOLD

STUDY AREAS	CASTE GROUPS						
	DOMINANT	HIGHER	OTHER	OBC	SCHEDULE CASTE	SCHEDULE TRIBE	SIGN.OF DIFFERENCE
NO TREATMENT							
GANDEVI (GUJ)							
(N)	82	5	9	2	19	124	
% Patients	2.4	0	3.4	0	0	5.7	
AKOLE (MAH)							
(N)	496	12	7	74	35	132	
% Patients	7.9	16.7	0	16.2	2.9	16.7	**
GARAG (KAR)							
(N)	391	77	109	15	81	85	
% Patients	22.8	16.9	24.8	20	13.8	22.4	
KARCHANA (UP)							
(N)	36	148	148	312	411	7	
% Patients	11.1	6.1	5.1	8	12.7	28.6	
RAILA (RAJ)							
(N)	136	25	164	36	93	33	
% Patients	17.6	12	16.1	5.6	15.1	18.2	NS
PHC TREATMENT							
GANDEVI (GUJ)							
% Patients	14.6	0	20.7	0	15.8	25.8	
AKOLE (MAH)							
% Patients	14.9	8.3	0	14.9	37.1	27.3	**
GARAG (KAR)							
% Patients	22.3	18.2	24.8	20	30.9	20	
KARCHANA (UP)							
% Patients	8.3	12.2	17.4	15.4	18.5	0	
RAILA (RAJ)							
% Patients	55.1	60	43	63.9	42.2	18.2	**
PRIVATE TREATME							
GANDEVI (GUJ)							
% Patients	82.9	100	79.3	100	89.5	61.3	**
AKOLE (MAH)							
% Patients	72.8	50	85.7	73	54.3	42.4	**
GARAG (KAR)							
% Patients	52.4	61	50.5	46.7	56.8	57.6	
KARCHANA (UP)							
% Patients	55.6	78.4	68.8	63.5	65	57.1	*
RAILA (RAJ)							
% Patients	3.7	16	14.8	16.7	4.3	12.1	**
DAI							
RAILA (RAJ)							
% Patients	19.9	4	16.1	30.6	10.8	39.4	**

Annex – III

PROPORTION OF PATIENTS SEEKING CARE FROM DIFFERENT SOURCES BASED ON EDUCATIONAL LEVEL IN THE HOUSEHOLD

STUDY AREAS	EDUCATIONAL LEVEL			
	LESS THAN PRIMARY	UPTO SECONDARY	MORE THAN SECONDARY	SIGN.OF DIFFERENCE
NO TREATMENT				
GANDEVI (GUJ)				
(N)	60	89	112	
% Patients	5	5.6	1.8	NS
AKOLE (MAH)				
(N)	174	345	237	
% Patients	14.9	8.1	9.3	*
GARAG (KAR)				
(N)	246	303	209	
% Patients	25.6	20.1	18.2	NS
KARCHANA (UP)				
(N)	200	349	513	
% Patients	13.5	6.9	9.4	*
RAILA (RAJ)				
(N)	279	154	54	
% Patients	15.4	16.2	13	NS
PHC TREATMENT				
GANDEVI (GUJ)				
% Patients	30	23.6	12.5	*
AKOLE (MAH)				
% Patients	14.9	8.1	9.3	*
GARAG (KAR)				
% Patients	24	22.1	22.5	NS
KARCHANA (UP)				
% Patients	12.5	15.8	17.7	NS
RAILA (RAJ)				
% Patients	45.9	48.7	53.7	NS
PRIVATE TREATME				
GANDEVI (GUJ)				
% Patients	58.3	64	88.4	**
AKOLE (MAH)				
% Patients	54.6	67	74.3	**
GARAG (KAR)				
% Patients	52	55.1	55.5	NS
KARCHANA (UP)				
% Patients	59	68.8	67.6	*
RAILA (RAJ)				
% Patients	8.6	6.5	20.4	NS
DAI				
RAILA (RAJ)				
% Patients	17.6	20.8	16.7	NS

NOTE : P = Standard IV completing S = Standard X completing

THE BAIF MISSION

BAIF's mission is to create opportunities of gainful self-employment for the rural families, especially disadvantaged sections, ensuring sustainable livelihood, enriched environment, improved quality of life and good human values.

This will be achieved through development research, effective use of local resources, extension of appropriate technologies and upgradation of skills and capabilities with community participation.

BAIF is a non-political, secular and professionally managed organisation.

BAIF Development Research Foundation

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